ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: SEPT 27, 2024 Case Number: 22-33

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Dr. M. ~~Dugin~~ Durgin

Premise Name: Spay Neuter Clinic

Premise Address: 2040 S Alma School Rd, Ste. 25

City: Chandler State: AZ Zip Code: 85249

Telephone: (480) 814-1008

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Joseph R Brekan

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: [redacted] Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. PATIENT INFORMATION (1):

Name: Enzo

Breed/Species: French Bulldog

Age: 1.7 Sex: M Color: Cream

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

Dr. Carolyn Duregger
Dr. Daniel Chelsie

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Amy Dunn
[redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: _____

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

See attached

Notes regarding the death of Enzo Brekan who was presented to the Spay Neuter Clinic - Chandler on 8/17/21 by Amy Dunn for the owner Joseph Brekan.

Enzo was a 1 year and 7 month old male French Bulldog who weighed 21.4# (9.7kg).

He was presented to Dr. M. Durgin for castration and surgical treatment for stenotic nares.

The insurance company representing the clinic and Dr. Durgin has informed Mr. Brekan that there were no mistakes made, and therefore there is no reason to compensate him for the loss of his beloved dog.

After review of the email from Dr. Durgin to Mr. Brekan and Enzo's medical record from that day, multiple mistakes have been found. These mistakes include inconsistencies in the doctor's statements, record documentation errors, lack of a thorough pre-surgical physical exam, inappropriate anesthetic protocol for the breed, lack of proper medical documentation, and lack of appropriate staff monitoring and support.

In the email to Mr. Brekan, Dr. Durgin shows a complete lack of willingness to take any responsibility for this unnecessary death, or to learn from the mistakes so that this will hopefully not happen again in the future.

Problems with the medical record:

- The record shows that his ID was not verified, the procedure was not verified and there was no ASA assigned.
- In Dr. Durgin's 8/30/21 email to Mr. Brekan she said "the only abnormality that I had noted with Enzo was his stenotic nares" but this was not documented in the record. The respiratory system was evaluated as normal.
- A thorough physical exam was not performed as the following body systems were entered as "Not Evaluated": Oral-Nasal-Throat, Abdominal, Genitourinary, Musculoskeletal, Integument, Lymphatics, and Neurological. No entry was put for the Rectal entry.
- Endotracheal Tube Size was entered as 0 even though later it was discussed that the technician finally got a size 6 in.
- Discordant timeline entries: The times entered for the the induction injection is LATER by 14 minutes than the times recorded for the CPR efforts.
    - 7:31am weight entered by Daniel T.
    - 7:33am note:
        - patient was fine until intubated and rolled on back
        - reversed with antisedan 0.11 ml im at 2:03 pm
        - 1 ml epi given iv at 2:05 pm
        - second dose given IC at 2:12
        - chest compressions and assisted ventilation provided throughout
    - 2:23pm note: when we pulled the Endotracheal tube it had blood on the end
    - 2:26pm note: TTDex 0.21ml from bottle 428 IM SarahT.
    - 2:39pm note: Pulled Enzo out of kennel he was laying slightly off to his side. Put pet on table he was breathing. I tried two different tubes before getting a size 6 tube in. I did notice that pets color seemed to be changing so I went to feel for a heart rate and did not feel one moved down to leg and did not feel one. Asked another tech to come over and see if they felt one. No one heard or felt heartbeat so I did call Dr. Durgin over. ST

Discussion of problems:

Dr. Durgin's statement in her email showed that Enzo had stenotic nares. This in combination with him being a brachycephalic breed is enough to document BOAS (brachycephalic obstructive airway syndrome) and necessitate a specialized anesthetic plan for that type of patient. The article "Breed-Specific Anesthesia" in the *Clinician's Brief* March 2012 discussed this issue. Three quotes from this article are:

- "Genetic differences and anatomic factors can contribute to variability and complication during anesthetic events."
- "Safe and successful sedation and anesthesia can be performed in any breed of dog and cat with proper preoperative workup and appropriate patient monitoring."
- Regarding Brachycephalic dogs: "Dexmedetomidine should be avoided because of the presence of high vagal tone in these breeds."

Another article "Anesthesia of brachycephalic dogs" in the *Journal of Small Animal Practice*, December 2018 (F. Downing & S. Gibson) recommended lower dexmedetomidine doses in these situations. They recommended 1-5 microgram/kg IV or IM dose for premedication. This is echoed by the article "Anesthesia for the Brachycephalic Patient" in the *World Small Animal Veterinary Association Congress Proceedings*, 2017 (Louise O'Dwyer). "Deep sedation of these patients can be associated with excessive relaxation of the upper airway muscles and worsened airway obstruction. Unless a patient is aggressive or dangerous to you, use lower doses of premedication."

The consensus is to either avoid Dexmedetomidine completely or to use a lower dose. This was not done in Enzo's situation. To further discuss the dose he was potentially given, there is a need to discuss the inadequate documentation of the the preanesthetic drug(s) he was given. The record states:

- "INDUCTION: TTDex"
- "DOSE: 0.21ml"
- "BOTTLE#: 428"
- "ROUTE: IM"
- "INITIALS/TIME: Sarah T. - 2:26 PM"

"TTDex" is not a technical medical abbreviation, but when googled it is know as the abbreviation for Telazol-Thorbugesic-Dexdomitor. In accurate medical record keeping you should never have to assume what something is. Dex could even be dexamethasone in medical situations. There is also no documentation of the drug(s) concentration(s) of the assumed mixture so we have no real way of knowing how much of each(?) drug he was given. Since standard protocol is to give the same volume of Antisedan (to reverse the effects of the dexmedetomidine) was given of the dexmedetomidine; we are again left to assume that he was given 0.11ml of dexmedetomidine, since that is the volume he was given of Antisedan at the time of attempted CPR. For Enzo's weight, this is an 11 micrograms/kg dose of dexmedetomidine. As stated previously, even if you disagree with the sentiment that it is better not to use this drug in this breed at all, it is at least twice the high end of the recommended "lower" dose range (1-5 micrograms/kg).

Moving on to probably the most egregious area of errors made in Enzo's situation, which was the lack of proper monitoring and medical support staff. The O'Dwyer article states "Anaesthesia of dogs suffering from BOAS should be managed using a minimal sedative premedication, pre-oxygenation and rapid intubation following induction." "Brachycephalic breed are particularly prone to airway obstruction during the perianesthetic period. They are prone to obstruct and die if left unattended after having been given sedatives or anesthetic drugs." Enzo was left in the cage without constant observation as shown by the quote from the record: "Pulled Enzo out of kennel he was laying slightly off to his side." Based on the times entered he was unattended in the cage for 13 minutes. He was then taken from the cage and intubation was attempted. We do not have a documented time for how long the individual technician struggled to intubate a high-risk patient by themselves. The reason we have no idea how long it took is that from this point in the record all of the times are suspect, due to the fact that they are all documented as happening PRIOR to his induction which is impossible. During the time that the technician was struggling to intubating Enzo, he went from breathing (per statement in chart) to having an abnormal color and found to be in cardiac arrest. It was only at this time (help was not sought during the time the technician was having difficulty intubating him) that a second technician was called over to decide if he was arresting. Only after both technicians checked him was the doctor notified. Help should have been sought immediately at the first difficulty in intubating him. As noted in the O'Dwyer article, "When intubating a brachycephalic patient, expect to use a much smaller endotracheal tube than typically used for other similarly sized patients. Carefully select a wide variety of sizes, but be ready with 2 tubes smaller than what you estimate to be the right size. A laryngoscope is a necessary tool for intubation as the amount of redundant tissue in the pharynx may reduce the visibility of the laryngeal opening."

As stated previously, multiple serious errors were made in this situation both medically and with the record keeping that would be actionable by the AZ Veterinary Medical Board. It is also disturbing that Dr. Durbin would not be able or willing to

recognize these issues per her quote "...there is nothing I would have changed about the induction, whether it was drugs used, or the amounts of those drugs or the staff that I had assisting me." Doctors need to be able to recognize their mistakes if they are to have any hope of learning from them and not repeating them.

[redacted]

From: Spay Neuter Clini[redacted]
Sent: Monday, August 30, 2021 10:46 AM
To: [redacted]
Subject: Veterinary Medical Record
Attachments: Enzo_MedicalRecord.pdf

This is my third attempt to reach you: I am so very sorry that Enzo did not make it to surgery nor recovered from the CPR attempt. Here are his records. I am not sure if you know that his ashes were returned today and are available for pick up. Your phone call came 5 days too late to prevent cremation- I wish it had been otherwise as well. I have done numerous surgeries on Frenchies, from c-sections to stenotic nares surgeries and have not had one that reacted to the anesthetics as Enzo did. We do use a reversible anesthetic so that we can recover them if they have an adverse event to the anesthesia; so it would have been nice to know exactly what happened. In the past, I have sent a couple of other animals for necropsy (the testing done to determine what caused a death) and no issues were found with drug dose. The one dog- there was not even any changes noted in the heart, however the cat did have heart changes that were considered congenital (he was born with them) but we could not hear those changes during his exam. The only abnormality that I had noted with Enzo was his stenotic nares which we had authorization to "fix" by enlarging the nasal openings during his surgery. There are so many questions, that if I could answer them, I would but the only thing that I can tell you is there is nothing that I would have changed about the induction, whether it was drugs used or the amounts of those drugs or the staff that I had assisting me. The ONLY thing that I wish would have been different, is that I could have sent him back home that day, surgeries complete with no negative after effects.

Please let me know if I can assist you in any other way.

Sincerely
Dr. Durgin

Spay Neuter Clinic - Chandler
(480) 814-1008
[redacted]

October 7, 2021

In re: 22-33 (Monika Durgin)

Personal Narrative of account regarding French Bulldog named Enzo owned by Amy Dunn

Patient presented August 17, 2021 for exam for neuter surgery.

7:15 AM: I saw patient with Veterinary Nurse Sarah Thomas. A Ms Dunn had come in with Enzo. I do not recall if there was a young man with her at the time. I do remember noting that patient had marked stenotic nares and offered to do the nares widening procedure while he was being neutered. Ms. Dunn commented "yes, he was talking about needing that surgery". I do not know if she was referring to her full-service vet or a male owner. An estimate was given for the neuter and stenotic nares procedures.
Patient was placed in a kennel that overlooks the surgery area and is easily seen from all 3 surgery tables.

7:30 AM: His anesthetic form and drugs were pulled by Daniel Thomas.

7:33 AM: The medical notes for his neuter and stenotic nares surgery were generated and an email was sent that had information regarding the small dog mouth. This was sent because they typically need daily dental care to help them keep their teeth. The information also included a list of laser surgeons that can perform a soft palate resection because of the stridor that he had, a Heartgard brochure and the brachycephalic airway syndrome information from VIN.

1:55 PM: Staff gave the TTDex IM while Enzo was in his kennel and he was watched until he was ready to be intubated. He was taken to surgery table 1 and Sarah Thomas was his surgical prep nurse. She began placing his tube and within seconds of her getting him on his back, she requested help from Rebecca Allen (our lead Veterinary Nurse) and then me because the dog's color was becoming blue in spite of having an endotracheal tube in. He was reversed with anti-sedan (an IM injection) and Daniel Thomas and I started CPR. Assistant Rebecca drew our emergency drugs while Sarah "bagged" Enzo. Staff also kept the log of emergency drugs and times given as they were drawn for me.

While we were doing these compressions, the owner was called and she was asked to come down immediately as Enzo was in cardiac arrest. She came with a young man. By the time they had arrived, Enzo had unfortunately passed. The owner was given the option of having her pet cremated or she could take him home. She was also offered a necropsy, which was declined as is noted in the medical record. I also indicated that we would cover the cremation costs should she elect that. There were no charges for the emergency drugs give. She asked for a few minutes with the body and then a paw print was made and provided to her. She elected cremation.

I updated the neuter notes to be CPR notes so the time the note was made does not reflect the time when those drugs were given- that is within the body of the CPR notes. Sarah also updated the anesthesia log but could not change the time that drugs were given to reflect the actual time that they were given.

Rebecca updated the records of her conversation with the owner after our duties for the day were completed so they do not reflect the exact time of when we spoke with the owner. My notes were entered very shortly after speaking with the owner.

On 8/24/2021 at 3:42 PM a voicemail was left by a Mr. Brekan who wanted to pick up the body and wanted copies of the medical records. Because this name was not associated with the file and the phone number did not relate to Enzo, I decided to ask Ms. Dunn if she knew this individual and would authorize release of the medical records to Mr. Brekan.

On 8/26/21 at 10:25 AM, I emailed the owner to let her know that the ashes were in and included the medical records. I also let her know that someone had called for the medical records but that person was not attached to her account.
At 3:36 PM I was informed that Mr Brekan was a co-owner of the dog and that I should send medical records to him by e-mail. An attempt was made to send medical record and a sympathy note however the e-mail was returned as undeliverable.

On 8/27/21 at 7:20 AM an email was sent to Ms Dunn informing her that the email address she had given for Mr. Brekan did not work.

2:21 PM, An attempt was made to send the records separate from the sympathy note to Mr Brekan but both bounced back.

8/30/21 at 9:57 AM a message was left on Mr Brekan's voicemail requesting a corrected email address as all attempts to email him had failed. Reminded owner that ashes were in.
11:13 AM, Ms. Dunn was in to pick up ashes.

9/8/21 2:06 PM. Returned a call from Mr. Brekan, could only leave a message.

9/9/21 2:30 PM Medical records were sent again to Ms Dunn and Mr Brekan. Since Mr Brekan had informed me that he was making a negligence claim, I turned the matter over to my insurance company.

In closing, I again extend my sympathies to the owner or owners however, all the veterinary medical care we provided was in compliance with the applicable standard of care. Unfortunately, this was an unforeseeable situation where the patient arrested unexpectedly. Thank you.

Monika Durgin, DVM

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

1740 W. ADAMS STREET, STE. 4600, PHOENIX, ARIZONA 85007
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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: AM Investigative Committee: Robert Kritsberg, DVM - Chair
Christina Tran, DVM
Carolyn Ratajack
Jarrod Butler, DVM
Steven Seiler - ***Absent***

STAFF PRESENT: Tracy A. Riendeau, CVT - Investigations
Marc Harris, Assistant Attorney General

RE: Case: 22-33
Complainant(s): Joseph Brekan
Respondent: Monika Durgin, DVM (1968)

SUMMARY:
Complaint Received at Board Office: 9/27/21
Committee Discussion: 3/1/22
Board IIR: 4/20/22

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow).

On August 17, 2021, "Enzo," an approximately 1.5 year-old male French Bulldog was presented to Respondent for a neuter procedure. During the exam, Respondent noted that the dog had stenotic nares and offered to widen the nares while the dog was under anesthesia for the neuter procedure – the pet owner agreed.

Later that afternoon, staff sedated the dog with TTDex and monitored him until he was ready to be intubated. While being intubated, staff noted the dog becoming cyanotic and a pulse could not be found. Respondent was alerted and CPR efforts were initiated. The pet owner was contacted and instructed to come to the premises as the dog had arrested.

When the pet owner arrived, she was informed that the dog had passed away.

Complainant was noticed and appeared.
Respondent was noticed and appeared telephonically. Attorney David Stoll was present.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Joseph Brekan*
- Respondent(s) narrative/medical record: *Monika Durgin, DVM*
- Witness statement(s): *Amy Dunn (co-pet owner); Dr. Durgin's staff.*

PROPOSED 'FINDINGS of FACT':

1. On August 17, 2021, at approximately 7:15am, the dog was presented to Respondent for a neuter procedure. Upon exam, the dog had a weight = 21.4 pounds, a temperature = 99.9 degrees, a heart rate = 150bpm, and a respiration rate = panting. Respondent did not evaluate the dog's oral/nasal/throat according to the medical record – the only systems that were noted to be evaluated were the dog's eyes, ears, cardiovascular and respiratory – all marked normal. However, according to Respondent she noted the dog had marked stenotic nares and offered to do the nares widening procedure while the dog was being neutered; the pet owner, Ms. Dunn, agreed. An estimate was provided. Respondent did not document in the medical record that the pet owner approved to have the nares widened as well as the neuter.

2. Later that day, at approximately 1:55pm, the dog was administered TTDex 0.21mLs IM. The cocktail amount of each medication and their concentrations was not documented in the medical record. Respondent provided the TTDex dispensing log which shows the medication amounts and concentration as follows: 2.5mL 10mg/mL butorphanol + 2.5mL 0.5mg/mL dexmedetomidine + 5mL Telazol cake (100mg/mL when concentration with 5mL of solution?).

3. The dog was monitored in his kennel until he was ready to be intubated. Ms. Thomas removed the dog from the kennel, placed on the surgery table, and began placing the endotracheal tube. Within seconds of placing the dog on his back, Ms. Thomas called for assistance due to the dog becoming cyanotic despite being intubated. Staff was unable to locate a heartbeat, therefore Respondent was alerted. The dog was administered the following while chest compressions were being conducted:
   a. Antisedan 0.11mL IM;
   b. Epinepherine 1mL IV; and
   c. Epinepherine 1mL IC.

4. Also while CPR was being performed, the pet owner was contacted and instructed to come down to the premises as the dog had arrested. Respondent reported that when the pet owner arrived with Complainant, the dog had passed away.

5. Respondent spoke with the pet owner. She offered cremation, taking the dog's remains home, or a necropsy. The pet owner chose to have the dog cremated at Respondent's expense and a paw print was made.

6. Complainant expressed concerns that several entries in the medical records were not time stamped properly as well as there being omissions from the medical records, including lack of exam findings and drug concentrations.

7. Respondent stated in her narrative, that she updated the neuter notes to be CPR notes therefore the time the note was made did not reflect the time the drugs were administered – the time the medications were administered were noted in the body of the CPR notes. Staff also updated the dog's chart therefore the time the anesthesia was administered could not be changed to reflect the actual time of administration. This was the same for staff documenting conversations that took place with the pet owners and the time stamp in the medical record not being the accurate time they spoke with the pet owners.

8. There was some back and forth communications with the pet owner, Complainant and Respondent. Complainant had requested a copy of the dog's medical records, however since his name was not on the medical record as a pet owner, Respondent contacted Ms. Dunn to ensure he had authorization to have a copy. Ms. Dunn confirmed Complainant was the owner of the dog as well. Respondent attempted several times to email Complainant, but had an incorrect email address. She also attempted to call to speak to Complainant but could only leave a voicemail.

COMMITTEE DISCUSSION:

The Committee discussed that the dog was not re-examined within the required 6 hour timeframe prior to being pre-medicated. Additionally, the dog was administered a higher dose of TTDex that would be appropriate for the dog's weight to achieve the amount of sedation needed to intubate the dog. There will be some respiratory depression with this drug combination especially in brachycephalic breeds. It is best to avoid over sedation with pre-anesthetic medications in brachycephalic breeds due to their inability to breathe easily and comfortably.

There was some confusion whether a necropsy was recommended. It would have been helpful to determine if there was an underlying condition that could have also contributed to the death of the dog.

The Committee further discussed that there was no mention of the dog's stenotic nares in the medical record. Respondent should have pre-oxygenated the dog prior to giving a respiratory depressant like dexdomitor. There was also concern that the dog was not properly monitored.

The Committee commented again that the dog was administered a dose much higher than required as indicated on TTDex chart with those specific concentrations of drugs.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the Veterinary Practice Act occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board find:

ARS § 32-2232 (11) Gross negligence; for failure to be aware of the proper dose of TTDex to be administered to the dog which led to respiratory depression and eventually death; and not properly monitoring the dog prior to surgery.

ARS § 32-2232 (18) as it relates to AAC R3-11-502 (H) (3) failure to perform an exam on the dog within 6 hours before anesthesia was administered or surgery was performed.

Vote: The motion was approved with a vote of 4 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

TR

Tracy A. Riendeau, CVT
Investigative Division

BEFORE THE ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

IN THE MATTER OF: MONIKA DURGIN, DVM HOLDER OF LICENSE NO. 1968 FOR THE PRACTICE OF VETERINARY MEDICINE IN THE STATE OF ARIZONA, RESPONDENT.	CASE NO.: 22-33 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

The Arizona State Veterinary Medical Examining Board ("Board") considered this matter at its public meeting on May 18, 2022. Monika Durgin, DVM ("Respondent") appeared on her own behalf for an Informal Interview that was held pursuant to the authority vested in the Board by A.R.S. § 32-2234(A) and was represented by attorney David Stoll, Esq. After due consideration of the evidence, the arguments and the applicable law, the Board voted to issue the following Findings of Fact, Conclusions of Law and Order ("Order").

FINDINGS OF FACT

1. Respondent is the holder of License No. 1968 and is therefore authorized to practice the profession of veterinary medicine in the State of Arizona.

2. On August 17, 2021, at approximately 7:15am, an approximately 1.5 year-old male French Bull dog ("Patient") was presented to Respondent for a neuter procedure. Upon exam, the Patient had a weight = 21.4 pounds, a temperature = 99.9 degrees, a heart rate = 150bpm, and a respiration rate = panting. Respondent did not evaluate the Patient's oral/nasal/throat according to the medical record – the only systems that were noted to be

evaluated were the Patient's eyes, ears, cardiovascular and respiratory – all marked normal. However, according to Respondent she noted the Patient had marked stenotic nares and offered to do the nares widening procedure while the Patient was being neutered; the pet owner, Complainant's girlfriend, agreed. An estimate was provided. Respondent did not document in the medical record that the pet owner approved to have the nares widened as well as the neuter. However, the abbreviation "SN" was noted on the authorization form.

3. Later that day, at approximately 1:55 p.m., the Patient was administered TTDex 0.21mLs IM. The cocktail amount of each medication and their concentrations were not documented in the medical record. In addition, the medical record states that TTDex was administered at 2:35 p.m. Respondent provided the TTDex dispensing log which shows the medication amounts and concentration as follows: 2.5mL 10mg/mL butorphanol + 2.5mL 0.5mg/mL dexmedetomidine + 5mL Telazol cake.

4. The Patient was monitored in his kennel until he was ready to be intubated. A member of the office staff removed the Patient from the kennel, placed him on the surgery table, and began placing the endotracheal tube. Within seconds of placing the Patient on his back, the same staff member called for assistance due to the Patient becoming cyanotic despite being intubated. Staff was unable to locate a heartbeat; therefore, Respondent was alerted. The Patient was administered the following while chest compressions were being conducted:

a. Antisedan 0.11mL IM;

b. Epinephrine 1mL IV; and

c. Epinephrine 1mL IC.

5. Also, while CPR was being performed, the pet owner was contacted and instructed to come to the premises as the Patient had arrested. Respondent reported that when the pet owner arrived with Complainant, the Patient had passed away.

6. Respondent spoke with the pet owner. She offered cremation, taking the Patient's remains home, or a necropsy. The pet owner chose to have the Patient cremated at Respondent's expense and a paw print was made.

7. Respondent stated in her response to the complaint that she updated the neuter notes to be CPR notes; therefore, the time the note was made did not reflect the time the drugs were administered – the time the medications were administered were noted in the body of the CPR notes. Staff also updated the Patient's chart; therefore, the time the anesthesia was administered could not be changed to reflect the actual time of administration. This was the same for staff documenting conversations that took place with the pet owners and the time stamp in the medical record not being the accurate time they spoke with the pet owners.

8. The Board concluded that Respondent deviated from the standard of care when she administered a high dose rate of TTDex to a high-risk breed. Doing so resulted in the Patient going into respiratory depression and eventual death. The Board also concluded that knowing the dog was a high-risk brachycephalic breed, Respondent deviated from the standard after the Patient was administered the TTDex by not ensuring that he was closely monitored.

9. A veterinarian is required maintain a written medical record reflecting the services the animal received and containing, at a minimum, the results of the examination, the concentration of the medications administered, and an accurate recording of when the medications were administered.

CONCLUSIONS OF LAW

10. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (11)** Gross negligence[1]; for failure to be aware of the proper dose of TTDex for a compromised animal that was administered to the Patient, which led to respiratory depression and eventually death; and not properly monitoring the Patient prior to surgery.

11. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (21)** as it relates to **A.A.C. R3-11-502 (L) (4)** failure to ensure the Patient was examined, or the exam was documented in the medical record, and ensuring timed entries documented into the medical record were accurate.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law it is **ORDERED** that Respondent's License, No. 3703 be placed on **PROBATION** for a period of one (1) year, subject to the following terms and conditions that shall be completed within the Probationary period. These requirements include eight (8) total hours of continuing education (CE) detailed below:

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[1] A.R.S. § 32-2201(9) defines "gross negligence" as the treatment of a patient or practice of veterinary medicine resulting in injury, unnecessary suffering or death that was caused by the carelessness, negligence or the disregard of established principles or practices.

1. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that she has completed five (5) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these five (5) hours by attending CE in the area of anesthesia. Respondent shall submit written verification of attendance to the Board for approval.

2. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that she has completed three (3) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these three (3) hours by attending CE in the area of medical record keeping. Respondent shall submit written verification of attendance to the Board for approval.

3. **IT IS ORDERED THAT** Respondent shall pay a civil penalty of five hundred dollars ($500) on or before the end of the Probation period. Civil penalty shall be made payable to the Arizona State Veterinary Medical Examining Board and is to be paid by **cashier's check** or **money order**.

4. **All continuing education to be completed for this Order shall be pre-approved by the Board.** Respondent shall submit to the Board a written outline regarding how she plans to satisfy the requirements in paragraph 1 and 2 for its approval within sixty (60) days of the effective date of this Order. The outline shall include **CE course details** including, **name, provider, date(s), hours of CE** to be earned, and a **brief course summary.**

5. Respondent shall obey all federal, state and local laws/rules governing the practice of veterinary medicine in this state.

6. Respondent shall bear all costs of complying with this Order.

7. This Order is conclusive evidence of the matters described and may be considered by the Board in determining an appropriate sanction in the event a subsequent violation occurs. In the event Respondent violates any term of this Order, the Board may, after opportunity for Informal Interview or Formal Hearing, take any other appropriate disciplinary action authorized by law, including suspension or revocation of Respondent's license.

NOTICE OF APPEAL RIGHTS

Respondent is hereby notified that she has the right to request a rehearing or review of the Order by filing a motion with the Board's Executive Director within 30 days after service of this Order. Service of the Order is effective five days after the date of mailing to Respondent. *See* A.R.S. § 41-1092.09. The motion must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R3-11-904. If a motion for rehearing or review is not filed, the Board's Order becomes final 35 days after it is mailed to Respondent. Respondent is further notified that failure to file a motion for rehearing or review has the effect of prohibiting judicial review of the Order, according to A.R.S. § 41-1092.09(B) and A.R.S. § 12-904, et seq.

Dated this 27th day of June, 2022.

Arizona State Veterinary Medical Examining Board
Jim Loughead
Chairman

By: Victoria Whitmore
Victoria Whitmore, Executive Director

Original of the foregoing filed this 27th day of June, 2022 with the:

Arizona State Veterinary
Medical Examining Board
1740 W. Adams St., Ste. 4600
Phoenix, Arizona 85007

Copy of the foregoing sent by certified, return receipt mail this 27th day of June, 2022 to:

Monika Durgin, DVM
Address on file
Respondent

this 27th day of June, 2022 to:

David Stoll, Esq.
Beaugureau, Hancock, Stoll and Schwartz, PC
302 E. Coronado Rd
Phoenix, Arizona 85004

By: _____
Board Staff